

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2857AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2009
NAME OF PROVIDER OR SUPPLIER JOY'S REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 4235 PATTERSON AVE LAS VEGAS, NV 89104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 8/6/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed for 10 Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness Category I Residents. The census at the time of the survey was 9. Nine resident files were reviewed and 3 employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of A. The following deficiency was identified:	Y 000		
Y 435 SS=F	449.229(4) Fire Extinguisher; Inspection NAC 449.229 4. Portable fire extinguishers must be inspected, recharged and tagged at least once each year by a person certified by the State Fire Marshall to conduct such inspections. This RULE: is not met as evidenced by: Based on observation on 8/6/09, the facility failed to ensure 1 of 2 facility fire extinguishers were recharged. The fire extinguisher in the living	Y 435	<p><i>Acceptable POC 8/11/09</i></p> <p>Y435-</p> <ol style="list-style-type: none"> 1. The fire extinguisher located at the living room was recharged after the survey by A-1 National Fire Co. on 08/07/09. 2. The Administrator instructed the caregiver to make a monthly inspection of the fire extinguishers to ensure that the charge gauge are recharged and tagged must be current and inspected each year by a person certified by the State Fire Marshall to conduct such inspection. 3. The Administrator will monitor for compliance. 4. 08/07/09 <p>Attachment #1 - Copy of A-1 National Fire Co. Work Order</p> <p>Fire Extinguishers Monthly Inspection Report</p> <p>RECEIVED AUG 10 2009</p> <p>BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA</p>	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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If continuation sheet 1 of 2

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Y 435	Continued From Page 1 room had a current inspection tag but the charge gauge indicated it was discharged. Severity: 2 Scope: 3	Y 435		

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